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MAY—JUNE 1991

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THE
Hampden Hippocrat
MAY—JUNE 1991

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On our cover is the State Hospital located in Northampton Massachusetts, see related articles in this issue

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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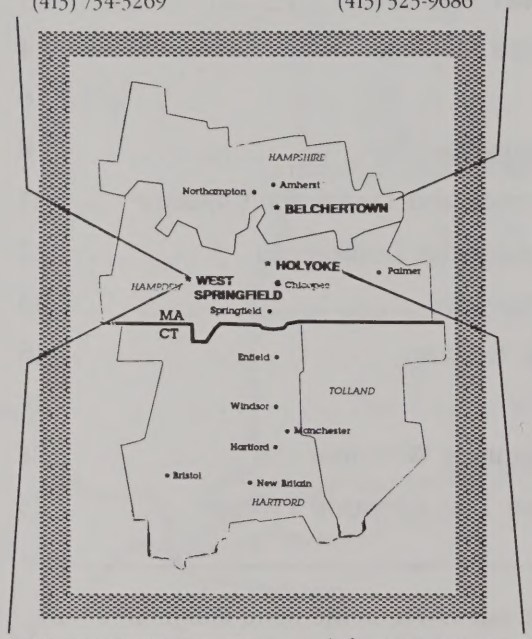

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CHALLENGE

PHYSICAL THERAPY AND REHABILITATION, P.C.

QUALITY AND CONVENIENCE

From the Editors

This issue focuses on psychiatry in Western Massachusetts. We are grateful to Deborah Gilman, M.D., for her help in acting as guest editor for this issue. The cover picture shows Northampton State Hospital, the largest inpatient psychiatric facility in the area.

You will notice that the format of the ***Hippocrat*** has changed once again. We were fortunate in having the professional advice and assistance of Soni Clarke, a member of the staff of the ***New England Journal of Medicine***, in creating the design, and of course the welcome cooperation of the staff at Rainbow Graphics, our long-suffering publishers.

The Hippocrat is always changing, which is a sign of health. Our hope is to continue to improve the magazine with each issue. We know that the members of the District Society have talent, and we invite those of you who are interested to participate in producing our journal. ■

"Thanks Dr. Manuel!"

Drs. Keenan and Mullan sent the following letter on behalf of the society to Dr. Barry Manuel, the outgoing president of the Massachusetts Medical Society.

Dear Doctor Manuel:

I am writing on behalf of the Executive Committee of the Hampden District Medical Society to express our heartfelt thanks for the superb job you have done in obtaining premium reductions in professional liability insurance policies held with the Joint Underwriting Association.

We thank you for being so articulate a representative before both the JUA and the Insurance Commissioner. Through tremendous effort on your part, you have obtained an outstanding victory for the physicians in our Commonwealth.

Each and every member of the Hampden District Medical Society stands with us in saying thank you for a difficult job well done. ■

Sincerely yours,

Joseph P. Keenan, M.D.
President

Mark J. Mullan, M.D.
President-Elect

The ABMT NCI Trials; or, How Not To Pay For 40,000 Transplants

Lee E. Mortenson, the author of the following article, is the Executive Director of the Association for Community Cancer Centers, an advocacy organization based in the Capitol area.

Those who do not remember history are forced to repeat it. And so, let us take off our rose-colored glasses and see if we can refresh our memories.

Long ago, there was a prolonged war between two countries over a stolen prize. A siege was made of the great city of Troy and, as time passed, the Greeks despaired of ever overcoming the defenses of that vast fortress. One night, the Greeks retreated, leaving a wooden horse at the gates of Troy. The Trojans accepted the horse as a gift and hauled it within the citadel, unaware that the horse's belly was full of Greek warriors. The Trojans were dead meat in the morning.

How does this history lesson apply to today? After years of debate about payment for off-label drug uses and what is and is not experimental, the National Blue Cross and Blue Shield Association had a revelation. In a highly publicized moment of compassion, it offered the cancer community quite a present: funding for autologous bone marrow transplant (ABMT) trials developed by the National Cancer Institute (NCI) for breast cancer patients. What a present. Let's cart this horse right in!

"Oh, what a cynic," you say? I wish. The week after this announcement, attorneys for the Blues were in Federal Court in Baltimore defending the Maryland Blues in a big-time law suit brought by a breast cancer patient who was being denied payment for ABMT. The plan's lawyers cited the new clinical trial at NCI as evidence that the procedure was experimental and should not be paid for until the NCI research trial is completed and the evidence is conclusive!

Okay, kids, are we clear about this yet? Let's check our math. If it takes approximately 7 years to complete the NCI trial (follow-up, results, publication, etc.) x approximately 6,000 women per year who are eligible for the procedure = 42,000 women—1,200 total women on the NCI trial = 40,800 ABMT's the Blues don't have to pay for.

Now let's say 20 Blues' plans invest in this little adventure. It costs each plan about $100,000 per transplant x 10 per year or $1 million per year. A major investment, right? But what about the other 40,000 transplants? Let's just call this a substantial savings, shall we?

The Blues have been repeatedly losing AMBT cases in court. Lots of clinicians and researchers are suggesting that this procedure is within the framework of "acceptable medical practice" for some breast cancer patients, and that the Blues' plans should pay for the procedure.

But folks, let's be clear about this great present. Beware Blues' plans bearing gifts! It is nothing more than a legalistic ploy not to pay for the vast majority of transplants.

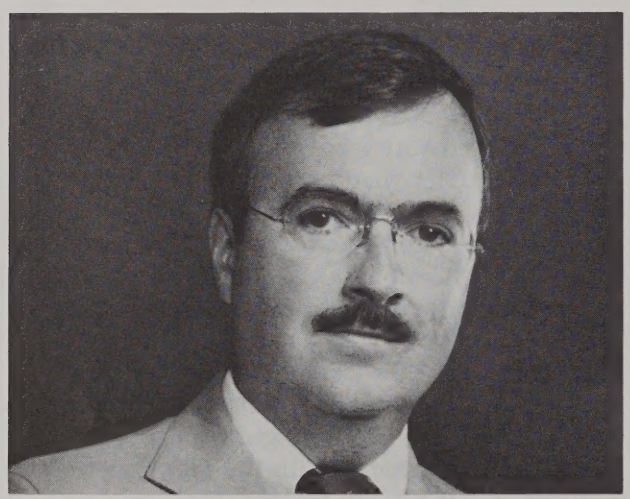
Frankly, rather than bringing their present into our gates, I think we ought to haul it into the public square. Let's tell Blue Cross and Blue Shield subscribers about this ploy. Let's read them the courtroom documents of this fine, charitable organization. Then let's stuff all the legal paperwork under the belly of the beast and light a match to it. The flames should be high enough and hot enough to make our friends uncomfortable with the fact that we remember our history lessons, too. ■

For All Physicians

The American Lung Association of Massachusetts has available to physicians a TWO MINUTE WARNING KIT to assist them in helping their patients quit smoking. The TWO MINUTE WARNING KIT is FREE to all physicians and can be ordered by calling Carol Magrone at the Lung Association Office, Phone: 737-3506. ■

Thanks For Your Concern!

As my term as president of the Hampden District Medical Society draws to a close, I would like to express my appreciation at the honor bestowed upon me by serving in this office for the past year. We have a vibrant, active and dedicated membership, who have



Joseph P. Keenan, M.D., President

demonstrated their concern for the public good by their investment of time and energy in the various activities sponsored by the Hampden District Medical Society over the past year. It is truly an honor to have served as president of such an organization; one that I will long cherish.

This has been an eventful year. A monumental change occured when the office of the Hampden District Medical Society moved from the Springfield Municipal Hospital to our new home at 1111 Elm Street in West Springfield. Leaving the home that we enjoyed for almost a quarter century was not easy, but the move was expertly orchestrated by Carol Nystrom and Donna Zitka. It was carried out very smoothly with minimal disruption of our member services. Attendance at the monthly executive committee meetings has gone up and it is nice to be able to seat all the members of the committee around the table in our new spacious office.

One of my top agendas for the Hampden District Medical Society this past year has been to increase the public profile of our organization, one being interested in civic/community needs. We have been very successful in this regard. Networking takes time—developing credibility as a serious participant in dealing with community problems and needs also takes time and commitment. Medical organizations oftentimes are criticized for being interested only in the socioeconomic welfare of their members. This is not the case with the Hampden District Medical Society!

The outpouring of support on the part of our members has been warmly received by the director of the Health Care for The Homeless. The director ot this organization was amazed at the spirit of volunteerism that was shown by our members in response to their call for help. Over 60 physicians responded to the letter we sent requesting support for this program.

The "Toy Drive" that was organized by Carol Nystrom and coordinated with our open house in December is another example of our community-mindedness. The cynical person might ask, "What difference does a toy collection make?" Yet, the impact that such activities generate goes far beyond the simple toys that were given to the children in the homeless shelters. Rather, it makes a clear statement that the Hampden District Medical Society, as an organization, acknowledges that there is a need in this area. Even though we can't supply all the solutions/answers, none the less, we are interested and concerned as an organization!

The AMA/ABA Drug Education program was carried out at the Westfield Boys and Girls Club in March. It was enthusiastically received by the students and attendents. The format of physician/lawyer teams was very successful—it is hard to say who benefitted more, the teachers or the students. This is another example of a commitment of the Hampden District Medical Society to become involved in activities that deal with societal problems, hopefully, for the benefit of the community at large. The president-elect of the Hampden County Bar Association, Bill Fitzgerald, was my cohort in this program and the cordial working relationship that we developed can hopefully be continued by future presidents of both organizations. We have many common concerns and much can be accomplished by continued dialogue.

Participation in organized medicine also gives benefits to its members. Change is frustratingly slow at times and seems to move at a snail's pace, yet, if we don't keep pushing, no progress would be made at all. This year tremendous success was obtained for the physicians of the Commonwealth through the diligent and tenacious efforts of Barry Manuel, president of the Massachusetts Medical Society, in terms of malpractice insurance reductions. The JUA has agreed to the largest reduction of malpractice insurance premium rates to physicians in the entire country. As a result of the efforts of Dr. Manuel, greater than a 25% reduction, in addition to elimination of the DPL for the 91/92 rate year was obtained. He has also been instrumental in keeping the pressure on the state legislature for malpractice tort reform. He has proposed an alternate dispute resolution route for patients to follow. This is an alternative to going through the usual civil court system. Hopefully, with continued concerted effort by the Massachusetts Medical Society, meaningful reform will be realized in this area this year. Patience and perserverance are necessary for this endeavor to be successful.

The annual meeting of the Hampden District Medical Society is scheduled for April 23rd. Please make every effort to attend. Dick Garvey, the former editor of the Springfield Newspapers is the featured speaker and it will be a delight to hear him speak about the history of medicine. The election of officers will also occur at the annual meeting and I wish Mark Mullan, our president-elect, an exciting and successful year. Thank You. ■

Hampden District Medical Society/Hampden County Bar Association Partnership for the prevention of substance abuse. Standing from left to right: Armand Aliotta, M.D., Joseph Deleo, Esq. Gopal Malladi, M.D., David A. Berndt, Esq., Francis Horrigan, M.D. Seated from left to right: William M. Fitzgerald, Esq., President, Hampden County Bar Association, Joseph P. Keenan, M.D., President, Hampden District Medical Society.

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Psychiatry 1991
More To Do, Less To Do It With

Benjamin Liptzin, M.D., the author of the following article, is Chairman of the Department of Psychiatry at Baystate Medical Center, and Professor and Deputy Chairman of the Department of Psychiatry, Tufts University School of Medicine. Dr. Liptzin is a graduate of Yale University and the University of Rochester School of Medicine, and served his residency at the University of Virginia Hospital, Charlottesville. He is the former director of the Geriatric Education Center at Harvard University.

I still find psychiatry to be intellectually and professionally exciting.

In 1991, the field of psychiatry is experiencing what Charles Dickens might have called "the best of times and the worst of times". It is the best of times because of all the advances in our understanding of basic neuroscience, clinical diagnosis, and effective treatment strategies for most psychiatric disorders. Within neuroscience the advances include the identification of multiple neurotransmitters in the brain; the application of molecular genetic techniques to conditions such as bipolar effective disorder (manic-depressive illnesses) or Alzheimer's Disease; the availability of neuroimaging techniques such as Magnetic Resonance Imaging (MRI), Single Photon Emission Computed Tomography (SPECT) and Positron Emission Tomography (PET) scans which provide information on brain function as well as structure; the ability to transplant nerve cells into the brain and have them not only survive but produce the hoped for neurotransmitter. With respect to clinical diagnosis, we have learned that panic disorder (with symptoms of intense fear, sweating, tachycardia, etc.) is a discrete entity which is closer to affective disorders than to anxiety disorders; obsessive-compulsive disorder is much more common than previously recognized; that "senility" is not a normal concomitant of aging but rather is due to a number of brain diseases but primarily a late-onset form of the disease described by Alzheimer. With respect to treatment, lithium has revolutionized the treatment of bipolar affective illness with its ability to prevent future episodes as well as to treat acute mania; specific serotonergic drugs such as fluoxetine (Prozac) or clomipramine (Anafranil) along with behavior therapy can significantly reduce the symptoms in severe obsessive-compulsive disorder; panic disorder responds better to the "anti-depressants" imipramine (Trofranil) or phenelzine (Nardil) than to anti-anxiety agents such as diazepam (Valium) or chlordiazepoxide (Librium) but also responds to the benzodiazepine alprazolam (Xanax); specific approaches to psychotherapy have been shown in controlled studies to be effective in depressed patients. All of the above plus the ever-expanding list of therapeutic agents available for the treatment of depression, anxiety and even schizophrenia make this a very gratifying time to be practicing psychiatry in addition to our traditional role as psychotherapists.

Unfortunately, these are also difficult times to be a psychiatrist. Despite our increasing ability to help patients, insurance benefits are often limited or non-existant. No other specialty of medicine has arbitrary limits on the number of visits a patient can be seen. Aggressive managed care companies keep pressing for fewer and fewer outpatient visits and require a psychiatrist with an acutely suicidal patient in the office to

wait hours until a non-physician calls back with approval for hospitalization. Patients who are uninsured or whose insurance has run out are at the mercy of the services funded by the Department of Mental Health which are experiencing significant cutbacks due to the state's fiscal woes. In another area, the FDA and Sandoz were so skeptical of the ability of psychiatrists to properly monitor patients on the new drug clozapine (Clozaril) that they required all patients to use the company's "patient monitoring system" of weekly blood tests in order to obtain the drug. After tremendous outcry about the costs and infringement on medical practice, Sandoz backed down and unbundled the drug from the monitoring system. This incident was another reminder that often concerns about liability takes precedence over what will be most helpful to patients. The intrusion into medical practice was also shown in the new OBRA regulations on the use of psychotropic drugs in nursing homes. While many studies had raised questions about the "overuse" of drugs such as neuroleptics in nursing home residents, the new regulations require substantial additional documentation for the physician's judgment and have the potential for criticism by a surveyor who doesn't know the patient.

Given all this, would I advise my daughter in college to pursue a career in psychiatry? Or would I do it all over again? Despite the changing economic realities and the intrusions on our practice, I still find psychiatry to be intellectually and professionally exciting. The ability to work closely with another person and provide comfort and relief is tremendously gratifying. Every new patient is like opening a part in future chapters. I just hope we can preserve our commitment to patients in the face of budgetary and cost-cutting pressures. ■

Announcement

American Medical Association
Hospital Medical Staff Section
Seventeenth Assembly Meeting
June 20-24, 1991

Medical Staffs from across the country are encouraged to elect a medical staff representative to participate in the AMA-HMSS Assembly Meeting, June 20-24, 1991 at the Chicago Marriott Hotel in Chicago, Illinois.

The HMSS Assembly provides medical staffs with a unique opportunity to participate in the policymaking process of the AMA. In addition to the Assembly Meeting, an educational program on the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Practice Parameters will be presented.

For information about the AMA-HMSS, please call (312) 464-4754 or 464-4761. ■

Attention All Physicians

The Massachusetts Department of Public Health has revised immunization regulations effective August 1, 1991 for children entering the seventh grade and for college students. A second dose of live measles containing vaccine will be required for all children entering the seventh grade.

Similar regulations also apply to all full-time undergraduate or graduate students born after 1956. This also applies to every full-time or part-time undergraduate or graduate student in a health science program, regardless of birth date, who is in contact with patients.

For further information, please contact the regional office in Amherst at 545-6600. ■

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A Day in the Life of a Psychiatrist

There is a real paradox in my writing and thereby disclosing what I think and feel. It is my job to do the opposite: to listen and hear others out. So, as I now face this task, I realize what a difficult question I ask of my patients, "Tell me about yourself."

One thing I won't do is start like my first patient did this morning. He is about forty years old, hair slicked back, and well cologned. He strides in for our initial meeting, expresses little anxiety about being in my office and immediately launches into a detailed history. He goes through his depression, suicidal preoccupations, alcoholic binges, and marital infidelities, in a major gush of disclosure. Only at the end of the 45-minute session does he ask if all is held in confidence, even from his wife whom he would like to include in some future sessions. My answer is that confidentiality will be maintained (although I probably won't do couples' therapy while he is involved in extra-marital activity). More to the point, however, why does he first disclose and only later determine the ground rules? Shouldn't the order be reversed? Indeed, I am more impressed with that style than with the contents of his revelations. He is demonstrating for me his action orientation and impulsivity. First he acts, then he worries about the consequences. Could this be part of his problem?

So I will be more careful than he was in the limits and rapidity of my disclosures. Indeed, I've already disguised the material to protect the patient's privacy. I will continue in the way I tell my new patients to proceed: "Why don't you start anywhere; it doesn't have to be the most important or relevant thing and we'll see where we go."

I keep learning more about human nature and about myself.

Therefore, if you really want to know more about the kind of work that I do, you'll have to be patient and read on, I may or may not tell you a whole lot. That reminds me of someone I treated many years ago. He spent some twelve sessions only talking about his hobby. It was a very interesting hobby, I might add. It was something like collecting papers and letters of important people in a particular era. He would buy and sell these things through catalogues and special trade shows. Each week he would come in and tell me of the past week's dealings, sometimes with special prized items to show me, but not a word about troubles or symptoms. I would dutifully ask what brought him to consult a psychaitrist and he would brush me off by saying he really needed to talk about the hobby that hour. So on we went, from week to week.

Finally, some thirteen sessions and thirteen weeks later, he came in and abruptly told me he wanted to stop talking about the hobby and get down to business with me. (By that time, of course, I was really very interested in the hobby!). Out came a very straightforward and terrible story. His wife was threatening to leave him if he didn't get help for his temper; his daughters refused to even talk to him; his mother was terminally ill; and his boss was trying to fire him. I asked him why he had not mentioned these things in the three months he had been seeing me. He replied: "I felt too bad to even think of my troubles. They were so overwhelming. All I could do was think about my hobby—that's the only positive thing in my life. Also, I needed to know if you are a patient person because I'm going to be here a long time!" And so he was.

Not everyone I see is a candidate for insight-oriented psycho-therapy. Patient #2 today will only be in for a twenty-minute session to manage his anti-psychotic medication. He tells me about increasing paranoid ideas, especially about his neighbors. He is concerned that some discarded green chewing gum he spotted on the sidewalk might be evidence that his neighbors are conspiring against him. The convoluted logic of his tale unfolds. He chews a lot of green gum himself, but he always spits it out in his wastepaper basket. The green gum discarded in the street might have been planted by some neighbor to accuse him of littering the parking lot. He wasn't quite sure if this was really true, so he agreed to increase his Thorazine from 300mgs. to 400mgs. a day and meet again in two weeks. In the meantime, he would call me if more "evidence" showed up. I reminded him that people are innocent until proven guilty and that if he spent more time with other people, he wouldn't be so prone to these "extra-suspicious" thoughts.

It is really frightening how paranoid schizophrenia can take over a mind and destroy a productive life. This man has a Ph.D., used to work for a prestigious consulting firm and was married with two small children when the disease struck. Now five psychiatric hospitalizations and twenty years later, he is incapacitated by the sight of discarded green gum on the street. How sad that I can do so relatively little for him, though he's actually doing better than he used to. He came to see me when the rope he was trying to hang himself with broke under his weight.

I'll go on to see another four or five patients, individually or as couples today, maybe go to the Psychiatric Grand Rounds at the hospital, and then finish off the day with a Group Therapy session. That's usual for me, but perhaps worth describing. It is an hour-and-a-half session in my office. (I do have a large office with lots of chairs—but no couch!). Ten patients gather each week at the same time to meet and do psychotherapy together as a group. It is a non-structured event but with careful, clear rules about confidentiality. Interactions outside the group and regular attendance. The meeting tonight started with a conversation about a new member who had dropped out after coming to only two sessions. He cited financial constraints as the reason for leaving the group, but most of the members (and eight agreed) felt the problem was otherwise.

Continued on next page

COMMITMENT

TO THE COMMUNITY

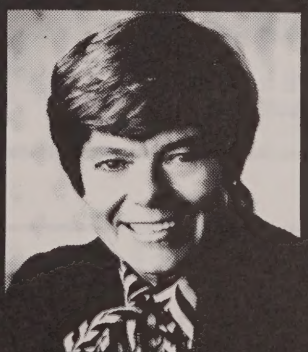
A strong commitment to my client's financial welfare is really an outgrowth of a long-standing commitment to the community. Helping people achieve their goals has always been part of me, whether by serving on local boards or advising individuals on investment choices.

TO FINANCIAL SERVICES

The best financial advice is frank and honest, based on solid research and analysis. That's what I give my clients. My job is to listen to their financial goals, make clear and concise recommendations, and then implement and monitor their choices.

TO EXCELLENCE

Commitment to excellence is more than the credentials and knowledge people need to do their jobs well. It's an attitude. I give my clients the best continuing service I can. That's why they come back, and recommend me to their friends, family, and colleagues.



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Life of a Psychiatrist

Continued from previous page

He had simply met with a very cold reception as he had begun to talk about his problems. His lack of insight was strikingly more evident in the group situation than it has been in the fifteen sessions I had treated him in individual therapy. He just blamed others in his life for his problems and felt rejected and unsupported by the rest of the group when they cast some doubt on the proper interpretation of his squabbles with his wife and mother-in-law. So now he is gone. I assured the group that I had talked to him on the telephone and that he was alright, and that led to a series of vignettes about how difficult it was to live with highly opinionated and sensitive spouses. One middle-aged patient said he realized now how unsupportive and unpsychological he could be. "I just don't know what to say at times, so I just change the topic or maintain a stoical silence." There were several more vignettes from others and then an admission from an older lady that somehow the session made her think about how she couldn't stand her husband's constant smoking. Since his retirement, he does nothing else—and people in his family all die of cancer. She wondered if his lack of caring about himself and her feelings about that had anything to do with her panic attacks. The Xanax and Prozac she was taking had helped, but she still had episodes of panic. They really did seem to start with the husband's planting himself in her kitchen with all his cigarettes and smoke! Not a very deep interpretation, but maybe the truth.

So that's the kind of thing I did today and do every day in my office. The funny thing is that I don't often get bored and people usually do get a whole lot better. They often thank me for what they've actually done themselves. I keep learning more about human nature and about myself. I also know more and more about psychopharmacology and wonder over and over about the interaction between chemical and our brains and feelings. The software of our experiences in life and the consequent feelings seem to interact in a complex feedback loop with the hardware of our brains and neurons. Ours is a computer that may get better as it is used. But then sometimes it fails, and I am the diagnostician and appointed fixer. Which is not to say that I am always up to the task, But one can always try and after awhile sometimes one sees progress. Just as with this little article. I started, worked at it some, and now I am done. ■

Jay Pomerantz, M.D., who contributed this article practices psychiatry in Longmeadow.

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Competence and Decisional Capacity: Who Decides?

Anita Sarno, the author of the following article, is a Partner at Bulkley, Richardson and Gelinas, and a frequent contributor to the ***Hippocrat*** *on matters dealing with the interface between law and medicine.*

Our societal emphasis on the rights of individuals has given our legal system a shape and form that is unique in the world: we go to great lengths to safeguard personal freedom. A most fundamental aspect of personal freedom is the ability to move about freely, manage our own affairs, and make our own decisions, regardless of whether the choices we make are shared by the majority. We tolerate a wide range of human behavior, but even that tolerance must have its limits. At times, an individual's actions and choices call into question his ability to care for himself adequately.

Under certain circumstances, an adult's current and future ability to manage his/her own affairs may be so questionable that those responsibilities must be turned over to another person, called a conservator or guardian. In this instance, the ultimate decision is whether the adult is "competent", and that decision rests with the court. Of course, a judge lacks the expertise to assess functional abilities, so the court relies on physicians to provide medical information about the physical and emotional status of the individual. But the legal conclusion that the person is no longer "competent" to handle his own affairs and is not expected to regain that ability rests with a court.

Psychiatry holds an important place among the many and varied medical disciplines. Its practitioners are the experts in the diagnosis and treatment of mental disorders, so it is expected that colleagues in other specialties may seek out a psychiatric consult whenever there is a serious question about a patient's mental ability, particularly if the circumstances involve an evalutation in connection with a legal determination of competence. But there is a much more common assessment of an adult's mental ability that does not require either the direct intervention of a court and often may be made without the special expertise of a psychiatric consult.

An adult has a fundamental right to accept or refuse an offered medical treatment. This right of choice may be taken away only if the adult is not capable of reaching a rational decision. Someone has to make this determination, but it would be unworkable to require the medical community to put all such matters before a court. Likewise, it would impede the delivery of medical care to make psychiatric consultation mandatory whenever a patient's decision-making ability is at issue. Thus, the determination of a patient's capacity to make decisions rests primarily with the physician offering the treatment under consideration.

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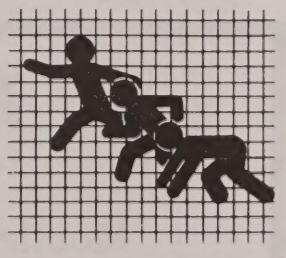

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Who Decides

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The capacity to make health care decisions means "the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision." ("An Act Providing For the Execution of Health Care Proxies By Individuals" G.L.C. 201D). A person is not considered incapable of decision-making merely because treatment is refused. The assessment of capacity requires further analysis.

Whether consciously aware of it or not, physicians make just such an assessment during every patient interaction. Often intuitively, the physician evaluates the patient's ability to understand and process the information being given and to weigh and consider the positive and negative consequences of a decision each time the patient is seen. This is an important part of each interaction, since a patient may lose decisional capacity only to regain it at another time.

In this respect, these assessments differ from either a legal finding of lack of competence, or a psychiatric diagnosis of a mental disorder, both of which imply a certain permanence of condition requiring intervention. In contrast, a determination as to a patient's capacity to make treatment decisions can and should be reevaluated frequently because this capacity may strengthen or weaken in response to any number of factors.

Assessing a patient's decisional capacity is an essential part of the physician-patient relationship. As with any medical evaluation, it requires care, throught and adequate deocumentation.* It is an assessment usually left in the capable hands of the treating physician. ■

*See, P. Appelbaum, M.D. et al, "Assessing Patients' Capacities to Consent to Treatment", N. Engl. J. Med. 319:25, p. 1635-1638 (1988)

AMA Leadership Conference

The AMA Leadership Conference was held in Miami Beach, Florida from February 15th through the 17th. The theme for this year's meeting was, "Perspectives On A Profession—Exploring the Many Dimensions of Professionalism".

Health legislation issues for 1991 were discussed, as the Council on Legislation set its priorities for the coming year. The conference opening had Arthur Miller, J.D., of Harvard Law School conducting a Town Meeting exploring the challenges facing the medical profession. Senator Jay Rockefeller, III, spoke to the issue of assuring health access to all Americans.

Individual sessions that were memorable were Care at the Margins conducted by Justice Marie Garibaldi of the New Jersey Supreme Court. The session discussed ethical dilemmas that arise in treating patients at the beginning and end of life. Also excellent was the personal perspective of the many parallels between physicians and attorneys as presented by former Supreme Court Justice Warren E. Burger. Violence in America was the final general session with Dr. Antonia Novello, Surgeon General of the United States as a panelist.

The conference concluded with a call to action on behalf of professionalism and good medicine.

Audio tapes are available of the major sessions and members can borrow them by calling the Society's office, 736-7301. ■

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Accessing Mental Health Services

Marian Leveton, Ed.D., and Jim Haughey, Ed.D., have provided the following directory to Mental Health Services in Western Massachusetts.

If you have a referral and need to access the mental health system, first evaluate the immediacy and severity of the options available within the area. The following directory included basic information on emergency/crisis clinics and other outpatient and diversional services. This list is not exhaustive, but is meant to serve as a guide to the community mental health system. Note that some services are funded by the Department of Mental Health (DMH funded) while others have various restrictions on access based on third party coverage.

Emergency Care

PSYCHIATRIC CRISIS SERVICE—Community Care Mental Health Center located at 503 State Street, Springfield, MA 01109. 733-6661 Crisis. Open 24 Hours a day.

The Psychiatric Crisis Service provides services to persons who are experiencing a mental health crisis. These services include a 24-hour crisis intervention hotline providing information and referral, crisis assessment and intervention, counseling and support services. Other programs include psychiatric respite with 24 hour supervision and treatment on a crisis or planned basis, and suicide prevention services. DMH funded. Persons experiencing a mental health emergency are eligible. Serves Springfield, Hampden, Longmeadow, East Longmeadow and Wilbraham. Handicapped accessible.

MT. TOM INSTITUTE FOR HUMAN SERVICES, INC.—located at 507 Appleton Street, Holyoke, MA 01040, 536-5673. Open Monday through Friday 9:00 a.m.-5:00 p.m.

The Mount Tom Institute provides services to those persons who are suffering or recovering from mental illness. The Institute's programs include a 24-hour crisis hotline, emergency psychiatric care, residential care and constellation of diagnostic and therapeutic programs designed to provide mental health treatment. DMH funded. Crisis line for anyone in need. Others require DMH referral. Serves Holyoke, Chicopee, Ludlow, Palmer and Monson. Handicapped accessible.

PSYCHIATRIC CRISIS SERVICE OF WESTFIELD, Westfield MA. Open 24 hours a day.

The Psychiatric Crisis Service provides services to persons who are experiencing a mental health crisis. These services include a 24-hour crisis intervention hotline providing information and referral, crisis assessment and intervention, counseling and support services. Other programs include psychiatric respite with 24 hour supervision and treatment on a crisis or planned basis, and suicide prevention services. DMH funded. Persons experiencing a mental health emergency are eligible. Serves Springfield, Hampden, Longmeadow, East Longmeadow, Wilbraham and Westfield. Handicapped accessible.

Psychotherapy and Counseling Clinics

CHILD GUIDANCE CLINIC OF SPRINGFIELD—located at 110 Maple Street, Springfield, MA 01105, 732-7419. Open Monday and Wednesday 8:00 a.m.-6:00 p.m.; Tuesday and Thursday 8:00 a.m.-8:00 p.m.; Friday from 8:00 a.m.-5:00 p.m.

Outpatient counseling/treatment, juvenile court clinic, diagnosis, evaluation, school consultation, early prevention program 3 mos.-3 years, early childhood program up to 5 years old, child, adolescent and family program, protective services treatment program. FEES: Sliding fee, insurance. To be eligible you must be under the age of 22, parent seen directly regarding child.

COMMUNITY CARE MENTAL HEALTH CENTER, INC.—located at 273 State Street, Springfield, MA 01103, 736-3668. Open Monday-Friday 9:00 a.m.-5:00 p.m., call for evening hours.

The Community Care Center offers a comprehensive range of mental health services. Programs offered include Crisis Intervention; Diagnosis and

Continued on next page

Mental Health Services

Continued from previous page

Evaluation; Brief Therapy, Individual, Group, Marital, Family Therapy; Psychological Testing; Day Treatment; Medication Clinic; Dual Diagnosis for Substance Abuse and Mental Retardation; Geriatric Programs and Services. FEES: Sliding Scale, Medicaid and insurance. Persons aged 17 and up are eligible. Serves Hampden County. Triage and Assessment Primary Provider for Blue Cross Behavioral Health Assessment Program.

HAMPDEN DISTRICT MENTAL HEALTH CENTER—located at 367 Pine Street, Springfield, MA 01105, 734-3151. Open Monday-Friday 9:00 a.m.-5:00 p.m. Evening hours on Tuesday.

Outpatient counseling, therapy, medication clinic, consultation provided. Specialized services for the elderly offered. FEES: Third party insurance, sliding fee scale. Anyone in need of service is eligible.

LIGHTHOUSE PROGRAM—located at 235 Chestnut Street, Springfield, MA 01103, 736-9874. Open Monday-Friday 8:00 a.m.-4:30 p.m. Tuesdays 8:00 a.m.-7:00 p.m. and every third Saturday 10:00 a.m.-3:00 p.m.

Psychological Rehab. Center, Pre-vocational, vocational training. Non-clinical, no meds. FEES: None. (Need lunch money, etc.) To be eligible you must have a major mental illness and be refered by DMH.

JEWISH FAMILY SERVICES OF GREATER SPRINGFIELD, INC.—located at 15 Lenox Street, Springfield, MA 01108, 737-2601. Open Monday-Friday 8:30 a.m.-5:00 p.m.

The Jewish Family Services of Greater Springfield provides comprehensive range of counseling and support services to all individuals regardless of race, religion or creed. Services include individual, family, group, and marital counseling, guardianship programs for the elderly; assistance to Jewish refugees, adoption and consultation services for schools, social agencies and physicians. FEES: Sliding fee scale. Insurance accepted. Anyone in the Pioneer Valley area is eligible for most programs. Handicapped accessible.

FORENSIC SERVICES—located at 110 Maple Street, Springfield, MA 01105. 732-7419 or 781-8100 (Court Clinic) ext. 2016. Open Monday-Friday 8:30 a.m.-5:00 p.m.

Forensic Services provided mental health services to court involved adults. Services include clinical consultation and supervision to the House of Correction regarding treatment, medication and disposition, clinical consultation to the department, and psychological evaluations to determine competency, criminal responsibility and aid in sentencing. FEES: None. Mental Health Population is eligible. Serves Springfield, Indian Orchard, East Longmeadow, Hampden and Wilbraham.

GANDARA MENTAL HEALTH CENTER—located at 2155 Main Street, Springfield, MA 01107, 736-0395. Open Monday-Friday 8:00 a.m.-5:00 p.m.

Outpatient counseling, medication clinic, alcoholism/drug counseling, partial hospitalization, residential care, outreach, case management. FEES: Third party insurance/medicaid, sliding fee scale, DMH referral. Open to all in need; specialized services for hispanic, spanish speaking only.

CENTER FOR HUMAN DEVELOPMENT—located at 322 Bernie Avenue, Springfield, MA 01107, 733-6624. Open Monday-Friday 9:00 a.m.-5:00 p.m.

CHD provides varied services for youths in need. These programs include Children's Emergency Services, Specialized Foster Care, Center for Adolescent Resources, Pace, Alternative Detention Program and Comprehensive Emergency Services-West. Also available are Family Mediation Services, counseling and vocational services for the mentally retarded, residential programs for the mentally ill, services for the mentally ill elderly people, individuals,

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group and family counseling. DMH funded. FEES: None. Eligibility varies with program. Serves Hampden, Hampshire and Franklin counties.

CHILD AND FAMILY SERVICE OF SPRINGFIELD, INC.—located at 367 Pine Street, Springfield, MA 01105, 737-1426. Open Monday-Friday 9:00 a.m.-5:00 p.m. call for evening hours.

The Child and Family Services of Springfield provides a wide range of support services including marriage and family counseling, individual and group counseling, diagnosis and treatment of children, mutual support groups and other services. FEES: Sliding fee possible in Pioneer Valley United Way service area. No restrictions on eligibility. Serves the greater Springfield area. Evening hours available.

NORTHAMPTON CENTER FOR CHILDREN AND FAMILIES—located at 78 Pomeroy Terrace, Northampton, MA 01060, 584-1310. Open Monday-Friday 9:00 a.m.-5:00 p.m.

The Northampton Center for Children and Families provides services to youths age 8-19 with severe emotional distrubances. Services provided include residential treatment and special educational programs. FEES: None. Persons with primary diagnosis of severe emotional disturbances are eligible. Referrals through DMH and the school system. Handicapped accessible.

OSBORN CLINIC, INC—located at 299 Walnut Street, Agawam, MA 01001, 786-8990. Open Monday-Friday 8:30 a.m.-7:30 p.m.

Private Licensed Mental Health Clinic serving Western MA. Provides outreach therapy in-home and in-agency, and office therapy in Agawam location. Diagnostic testing services and psychiatric services complement the full range of child, family and adult therapy. FEES: Paid primarily by Medicaid or other third party. Arrangements for payment, either cash or third party eligibility. Serves all of Western Massachusetts. Handicapped accessible.

PHOBIA SOCIETY OF AMERICA-WESTERN MA CHAPTER—located at 63 Mulberry Street, Springfield, MA 01105, 732-0801. Open Monday-Friday 9:00 a.m.-4:30 p.m.

The Phobia Society of America provides services to persons suffering from various forms of phobias. Services include support groups, educational programs and materials, and an information line staffed by recovering agoraphobics for persons seeking information or wishing to speak to another phobic. FEES: None, except for newsletter-$10. Adults in Western Massachusetts are eligible.

RIVER VALLEY COUNSELING CENTERS, INC.—located on 141 Grape Street, Chicopee, MA 01013, 592-4632. Open Monday-Friday 9:00 a.m.-5:00 p.m.

The River Valley Counseling Center's service include individual, marriage and family counseling, elderly counseling, and outpatient substance abuse services. An outpatient sexual abuse treatment program is available through DSS referral. FEES: Sliding scale, third party insurance. Anyone eligible for outpatient services. Serves. Belchertown, Ludlow, Chicopee, Holyoke, South Hadley, Granby and Southampton. Handicapped accessible.

TRI-COUNTY YOUTH PROGRAMS, INC.—located at 16 Armory Street, Northampton, MA 01060, 586-6210. Open Monday-Friday 9:00 a.m.-5:00 p.m.

The Tri-County Youth Programs provide comprehensive services to troubled adolescents. Services include therapeutic foster care (SPARK), intensive foster care (Alternative Living for Youth-ALY), long term specialized foster care (NEXUS), after care follow-up, after school Day Treatment, the Hill Adolescent Center which is a long-term residential treatment center for the severely emotionally disturbed adolescent, and Tri-County High School, a state approved special education day facility. FEES: Contact agency. Eligibility referral through appropriate agency. Generally ages 13 through 22. Serves Western Massachusetts.

VALLEY HUMAN SERVICES, INC—located at 96 South Street, Ware, MA 01082, 967-6241. Open Monday-Thursday 8:00 a.m.-8:00 p.m.; Friday 8:00 a.m.-4:00 p.m.

Valley Human Services provides a range of services including counseling, day care, adolescent care, an emergency shelter for adolescents, job training for younger adolescents in need of family intervention, a parent aid program to support potentially abusive or neglectful parent and a GED training program. A 24 hour crisis hotline is also operated. FEES: Sliding scale for day care and counseling. No fee for other programs. Eligibility Ages vary with programs. Parent aids program requires a referral form. Others have restrictions.

WEST SPRINGFIELD COUNSELING CENTER—located at 507 Union Street, W. Springfield, MA 01089, 737-4718. Open Monday-Friday 9:00 a.m.-5:00 p.m.

The West Springfield Counseling Center's services include marriage and family counseling on-going abuse treatment, substance abuse treatment, and family life and parenting services to prevent child abuse and neglect. FEES: None for most programs, sliding scale for others. Family life/sexual abuse treatment need DSS referral (persons needing services for others). Serves primarily Westfield area, secondarily Hampden County. ■

From the MMS Regional Office

The Professional Credentials Verification Service

In response to requests from its membership and other key health-care professionals in the state, the MMS has embarked on a new venture... The Professional Credentials Verification Service (PCVS). The PCVS is a unique resource for the centralized collection, verification, and distribution of physician credentialing information. The service is offered to health-care facilities under contract with PCVS.

What is Meant by Centralized?

Currently, the process of credentialing involves much duplication of effort by both the health-care facility and the physician. Physicians must prepare separate applications for each facility in which he/she seeks affiliation. Also, each health-care facility to which the physician applies must gather information about the physician.

In an effort to streamline the process, medical societies in several states have developed centralized services for verifying credentials information. In a centralized service, a single entity collects, verifies and distributes the physician background information on behalf of multiple physicians and multiple health-care facilities. Each health-care facility retains the responsibility for making its own decisions about medical staff appointments and reappointments. The PCVS is the first such statewide program in Massachusetts.

How does the PCVS Work?

The PCVS utilizes standardized forms, which will be provided to physicians applying to those facilities contracting with PCVS. The standardized format will facilitate the efficient collection of primary source information on the physician's background, such as education, training, licensure, past affiliations, liability insurance coverage and information in the National Practitioner Data Bank. In addition, each facility's delineation of privileges application will be stored by PCVS, so that the privileges may be attached to the application sent to the applying physician. Subsequently, PCVS will also have the completed delineation of privileges to attach to each reference requested. The PCVS then provides the participating health-care facility with all the necessary information needed to make an informed and timely decision regarding the physician's appointment and granting of privileges. PCVS makes no decisions about the physician's membership or privileges. Each health-care facility retains the responsibility to review and evaluate the documentation provided by the PCVS.

Does the Service Satisfy Massachusetts' Regulatory Requirements?

The PCVS provides the participating facility with the physician information required by all pertinent laws and regulations.

In addition, interpretation of the regulations of the BRM and JCAHO guidelines allow for the MMS, as an independent entity, to act as a contractual agent and collect credentials information on behalf of a health-care facility.

Does the Service Protect Confidentiality?

A common concern raised is about the confidentiality of information gathered by PCVS. It is important to recognize that the MMS, as an organization, has experience working with sensitive information. A system exists which protects against the unauthorized access to all information stored in files as well as computers. In addition, the MMS has completed a national review of other centralized credentials services, selecting the most positive elements of each, including the software system. The software program was selected in a competitive bidding process to insure the confidentiality of the information collected on individual physicians.

What are the Benefits of PCVS?

Some hospital staff may feel that they already have a good credentialing system, are able to adequately track the necessary documents and prefer to maintain the system within their own facility. However, even the most sophisticated system is not able to benefit the physician who applies to more than one facility for staff membership. PCVS provides the unique ability to require the applying physician to complete a single application. This can be a significant enhancement to physician recruitment.

The benefits for the health-care facility and medical staff offices are many. With the emphasis on quality and risk management, membership in PCVS provides the medical staff with the necessary time to devote to the collection and analysis of quality assurance data. In addition, the risk to the facility is decreased when all of the required physician background information is verified with primary sources.

What is the Fee for Joining the PCVS?

PCVS will charge a one-time membership fee to hospitals for the service, which includes the cost of loading all data on the facility's existing medical staff. Additional assessments to hospitals include a charge of $125 for appointments and $25 for reappointments.

When will my Hospital be able to join PCVS?

In February 1991, the staff of PCVS began working with the Development Task Force, comprised of medical staff coordinators, hospital administrators, physicians who are involved with credentialing committees and representatives from key organizations (MA Hospital Association, MA Association of HMOs, MA Association of Medical Staff Services and the BRM). The purpose of the task force from February to June 1991 is to provide input on standardized application, reappointment forms, and to advise on the system's design during the pilot phase.

Six hospitals are presently participating in the pilot phase to test the standardized forms, including Mercy, Noble and Providence Hospitals in Western MA and Carney, Milton and Quincy Hospitals in Eastern MA. The pilot hospitals are also represented on the Development Task Force.

By July 1991, PCVS will be ready to enlist other hospitals around the state in this unique service. Should you wish to obtain additional information, contact Ms. Audrey Y. DeLoffi, the administrator or Ms. Brenda Gorman, the coordinator of the PCVS at the MMS 1-800-322-2303. ■

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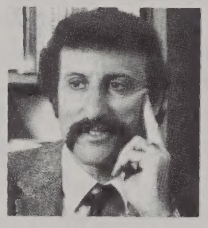

Jeffrey Geller trained in a psychodynamically oriented program at the Beth Israel Hospital in the 1970s. He then worked at the Northampton State Hospital from 1979 until 1984. Now he is Associate Professor of psychiatry at the University of Massachusetts Medical School and a consulting psychiatrist at the Westfield Crisis Center. His research is on the outcome of deinstitutionalization as it affected the patients at the Northampton State Hospital after the Consent Decree was published in the American Journal of Psychiatry in the summer of 1990.

Q When did you become interested in what you call public sector psychiatry?

A As a second year psychiatry resident at Beth Israel in Boston in 1975, I was sent on a six month rotation to the Worcester State Hospital. I decided then I was interested in dealing with those persons that were the sickest and the most disadvantaged. You find those people in the public sector.

Q How did that come about historically?

A The system that we have is the result of the failure of Dorothea Dix in the mid-nineteenth century to get a land grant bill signed by the President. This bill would have made the care of the persistently and chronically mentally ill the responsibility of the federal government. The bill passed both Houses of Congress, but was vetoed by the President. This responsibility has thus always rested with the state. Various chronic illnesses are covered by Medicaid (50% of Medicaid costs are paid by the federal government). The Medicaid program specifically excludes payment for inpatient psychiatric care in free standing psychiatric hospitals.

Q How did the (Northampton State Hospital) Consent Decree affect the state's handling of its responsibility for these patients?

A The Consent Decree is an ideological, not a clinical document. It was predicated on the belief that the negative symptoms of schizophrenia were due to being in an institution long-term. Therefore (according to this ideology), if you could remove people from the institution, then those effects ought to dissipate. If you could prevent them from ever entering the institution in the first place then those effects ought to never appear. Research has now shown that a substantial portion of these effects are independent of the low side of care and treatment.

There was also the belief that if you returned people to the community you could redirect them, with some minimal rehabilitation, on a more productive life course. In a fairly short period of time, people would progress through and graduate from the system. This would create new places for individuals to backfill.

That's not what's happened. Many of the individuals have needed the same care in the community that they needed in the institution. The day to day aspects of care provided by the state hospital that constitute asylum—room and board, companionship, camaraderie, some structure and organization to one's life—need to be provided for a large percentage of folks long-term. Since there is an annual incidence of new cases that eventually require that level of care, you have to perpetually expand the system until the number of positions in the community equals

the incidence rate minus the mortality rate for the population involved. It's not clear that anybody is going to fund that level of expansion of a community system. If western Massachusetts were an independent state, it would have far and away the highest per capita expenditure for community residential beds of any state. Still, there are families of the mentally ill who feel that not all the needs of patients in the community in western Massachusetts are met by the current system.

Q Why are the costs so high?

A The residential program's cost per bed is less than the state hospital's. But you have to include all the costs of having a patient in the community—case management, outpatient medical costs, day treatment programs. You also have to maintain a parallel system because people in the community decompensate and require hospital re-admission.

Suppose that having patients in the community is more expensive. I don't think that's necessarily bad if their quality of life is improved. Some individuals' quality of life has been vastly improved. For others it's not at all clear that there's been that improvement. We need to look at individual needs. We should avoid ideological stands which state that any one place is a better setting than any other place for everyone without even defining words like community.

Q In Massachusetts, it's possible to involuntarily commit someone to a hospital and then have them refuse treatment, usually medication. Then, for them to be given medication without their consent, a so-called Rogers order has to be obtained from a judge. What has been the impact of this?

A The Rogers orders have made the system considerably more expensive and cumbersome. Much of the time people's rights are better protected than they were before. I don't think that outcomes have changed much. There is not a large population of people who ought to be treated that aren't being treated.

We don't *entirely* respect a patient's rights. We do if their desires are in line with the current ideology. If an individual at Northampton State Hospital wants to be in the community and protests his confinement, that individual can get substantial legal representation to achieve that goal. If an individual has been in the institution and then been in the community, and he desires to live in the hospital, there aren't a lot of people rallying around to defend that patient's right and choice.

Q What do you think of the current process of emergency involuntary confinement? What should the standard be?

A The standard should include competence, not just potential for harm to self or others. I don't think we should go back to a standard by which we can involuntarily treat anyone we determine needs treatment. But I don't think that we should have the system that we have in Massachusetts. We have a structure where you can involuntarily hospitalize someone and then not treat them.

There are patients who will say "It is my greatest desire to never return to the state hospital. I'm taking medication and I understand that my mental health depends on my continuing to take it. I can even tell you that I understand that there's a link between my staying out of the hospital and taking my medication. I can also tell you in advance that if you give me the discretion, that at some point in the near future I will stop taking my medication. How do I know that? Because that's what's always happened in the past." For these folks to have their desire to remain in the community fulfilled, they need some element of coercion. The issue here is the relationship between capacity, competence, and compliance.

Q So what is the nature of the impaired judgement in these cases?

A One element is denial—that's shared with some other types of illness. There are also issues of insight. Then there's a lot of recent research to suggest that people with schizophrenia have a lot of very basic problems with information processing. You take these factors together and find that part of this disorder itself interferes with ability to comply with treatment—even if that's your expressed desire. From my perspective, coercion for a subset of this population is a therapeutic intervention. It's not inconsiderate of their wishes, it's considerate of their needs.

Q What do you think is the influence of the law on the practice of psychiatry currently? Has it gone too far?

A It certainly is more burdensome and expensive. We need a system that is less expensive and more efficient than the one we currently have in Massachusetts. Otherwise we are

Continued on next page

Interview Jeff Geller

Continued from previous page

spending a lot of money protecting some people's rights at the expense of other people's services. On the other hand, we have people calling for the liberalizing of commitment statutes because of the problems of the homeless mentally ill. Competency has to be the standard here. For a long time it has been the case that if you are mentally ill and prospectively dangerous, you could be involuntarily confined. If you are not mentally ill but labelled prospectively dangerous, even with a long record of recidivism, you cannot be involuntarily confined. I have never understood the legitimacy for that distinction.

In our current system, it is my own belief that the vast majority of psychiatrists would be more than delighted to have neither the authority nor the responsibility to involuntarily confine someone who is competent.

Society has an interest in the preventive detention of the mentally ill. If a hundred mentally ill people were involuntarily confined to prevent one heinous crime that would be OK because they're just the mentally ill. A similar plan to lock up young adult males with histories of drug abuse in urban areas in preventive detention would not be acceptable.

Q Do you see these psychiatric units within general hospitals as some sort of intermediary?

A No, because those units aren't going to keep people long term. No one is going to pay the bill. These units will provide acute treatment; people will have to receive their care some place else.

A terrible disaster of the state hospitals was that they were overcrowded, large, understaffed institutions, basically not very nice places. A tremendous asset was that they provided continuity and insulation from society. A tremendous asset of being in the community is that we've provided people with an opportunity to be more mainstreamed, to be less stigmatized, to participate in life to whatever degree they can. A terrible downside to the community is that we have people moving all over the place.

In the last fifty years of the existence of (Northampton) State Hospital there were two patients who had more than ten admissions; in a given year in the 1980s, 20% of a point in time sample of patients had more than ten admissions over a lifetime—some had more than 100. To me that's a real problem. I don't think there are simple answers to complex problems. In my own view we have too much ideology, not enough humanitarianism, and not enough clinical input. The bottom line is that we ought to be making individual determinations based on individuals' preferences and their needs.

Q What does the future hold?

A The residents that I participate in training have a much richer experience at the Worcester State Hospital then they do in the general psych unit. In the general hospital, with its third party payor utilization review and its managed care, the resident practices in a system which has a credo: get them in and get them out.

In the 1860s there was only the state hospital. In the 1930s, the state hospital jobs were the most sought after jobs in psychiatry. In the face of managed care, I think state hospitals are returning as sought after places where psychiatrists want to train and to work. ■

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Residency: Baystate Medical Center 1987-1989
Specialty: Internal Medicine

Jerry D. Ballard, M.D.
50 Maple Street
Springfield, MA 01103

Born: July 21, 1938
Premed: Mississippi State University 1956-1959
Medical: University of Missippi School of Medicine 1959-1963
Internship Fitzsimons General Hospital 1963-1964
Residency: Fitzsimons General Hospital 1964-1967 (Internal Medicine)
Fellowship: University of Colorado Health Sciences Center 1971-1972 (Rheumatology)
Specialty: Internal Medicine/Rheumatology

James R. Cook, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: May 23, 1957
Premed: University of Notre Dame 1974-1978
Medical: New York Medical College 1978-1982
Internship: Westchester Medical Center, Valhalla, NY 1982-1983
Residency: Westchester Medical Center 1983-1986 (Chief Medical Residency)
Fellowship: Westchester Medical Center 1986-1990 Columbian-Presbyterian, New York 1988-1990
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Baystate Medical Center
759 Chestnut Street
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Premed: University of Notre Dame 1979-1983 University of Pittsburgh January 1985-December 1985
Medical: Case Western Reserve University 1986-1990
Internship: Baystate Medical Center 7/90-Present
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Alison E. Wondriska, M.D.
305 Bicentennial Highway
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Medical: University of Vermont College of Medicine 1983-1987
Internship: Yale-New Haven Hospital, CT 1987-1988
Residency: Yale-New Haven Hospital, CT 1988-1990
Specialty: Pediatrics

Grace Makari-Judson, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: May 14, 1956
Premed: Harvard University 1977
Medical: Cornell University Medical College 1982
Internship: The New York Hospital 1982-1983
Residency: The New York Hospital 1983-1985 Memorial Sloan-Kettering Cancer Center 1986-1987 (Chief Residency)
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Continued on next page

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Continued from previous page

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Internship: St. Francis Hospital, Illinois 1987-1988
Residency: St. Francis Hospital, Illinois 1988-1990
Specialty: Internal Medicine

Kathleen I. Kurowski, M.D.
Baystate Medical Center
759 Chestnut Street
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All About The Adoption Process And The Role Of The Referring Physician.

Lisa Burch, A.C.S.W., who contributed this article, is Coordinator of Family and Children's services for Jewish Family Services.

Physicians are often uniquely positioned to make a significant difference in many lives through playing a referring role in the adoption process.

Jewish Family Service, a private not-for-profit agency providing services on a non-sectarian basis to individuals throughout Hampden County and the Commonwealth of Massachusetts, provides adoption services in accordance with State statutes and Office for Children regulations. The agency responded to forty-two inquiries from birth mothers over the course of the 1989-1990 fiscal year; actively counseled twenty-nine of those women; and has a waiting list of several hundred potential adoptive couples.

In essence, Jewish Family Service serves as the coordinator for all concerned parties in the adoption process, including the birthparents, the adoptive couple, the child, and referring professionals such as a trusted physician. The agency maintains a policy of strict confidentiality throughout the entire adoptive process; and takes the position that the appropriate role for agency staff is to educate, to listen, and to support whatever decision the client ultimately makes. Jewish Family Service promotes Cooperative Adoption, meaning that birth parents and adoptive couples may share information with each other and about each other to the extent that all parties involved can agree and feel emotionally comfortable.

The experience of both the prospective parents and the prospective birth parents are taken into account under State regulations. The birth parent, however, remains in the driver's seat. Jewish Family Service explains that initial birth parent counseling sessions—which often grow out of physicians' referrals—are entirely exploratory in nature. The agency reviews all of the options available to the birth parent, and specifically avoids the forcing of any one agenda—adoption included. "People must be able to live with whatever decision they make," explains Burch, "and it is in the best interests of all parties concerned that we present and discuss the options objectively. We help birth parents to clarify the options and to make informed decisions, whatever those decisions may be. Initial sessions constitute an exploratory process. We encourage physicians to refer parties to us precisely because of the non-binding nature of initial contacts: we ask physicians to let us know if there is someone who might want to consider this option, because we can help that individual sort through the possibilities."

"The birth parents remain the legal parents until they decide to relinquish the role of legal parents," Burch continues, "and that cannot take place until four days after the birth of the child—at the earliest.

State stipulations make it easier for referring physicians to become involved in the adoption process precisely because the rights of both birth parents and adoptive parents are respected and clearly delineated.

The following information is provided to physicians who are in a unique position to identify and refer potential birth parents and potential adoptive parents:

Traditional Adoption

This type of adoption, in which placements are made according to the agency's chronologically maintained waiting list, can involve a considerable wait on the part of prospective adoptive couples. Traditional placements are occuring less frequently; many families opt for the designated method of adoption, which often brings quicker results.

Open Adoption

Birth parents may now legally request an open adoption, in which they meet the adoptive couple, perhaps knowing names and addresses. There may be an ongoing exchange of letters, photographs and telephone calls, or the exchange may be limited to mutually agreed-upon time frames or frequencies.

Continued on next page

Adoption Process

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Designated Adoption

In this situation, a birth parent specifies the adoptive placement of the child with a particular family. The designation is often made on the recommendation of a referring physician or other professional.

For many prospective adoptive parents, designated adoption is an exciting and hopeful new option despite the risks. It allows and encourages active, energetic participation which is greatly appreciated after years of infertility testing and treatment; and in general, a designated adoption can take place more quickly than a traditional adoption, which is particularly of interest to couples who have waited to have children and then find themselves facing a lengthy wait for the adoption option.

Legal Release

Birth parents may not release parental rights and responsibilities until at least four days after the birth of the infant. Any plan made prior to this point therefore remains legally tentative and contingent upon the release. There is no waiting period during which a birth parent may change his/her mind following execution of the surrender; in the Commonwealth of Massachusetts a signed, notarized surrender of parental rights is irrevocable. Law does vary on this point from state to state.

The Referring Physician and the Adoption Agency

Often, parties may seek guidance and assistance from a trusted physician, in particular, and from other professionals, in general. Physicians may make educated suggestions and recommendations and often, find themselves compelled to do so; ultimately, however, they must make referrals to a licensed adoption agency must process the actual adoption itself unless the adoption takes place entirely within the confines of immediate blood family.

For More Information

For copies of agency brochures and handouts on adoption services and/or family and children's services at Jewish Family Service, please contact Lisa Burch, ACSW, LICSW, Coordinator of Family and Children's Services, or Laurie Walz, Office Coordinator. Jewish Family Service is located at 15 Lenox Street (at the "X"), Springfield, MA 01108, Telephone 737-2601. ■

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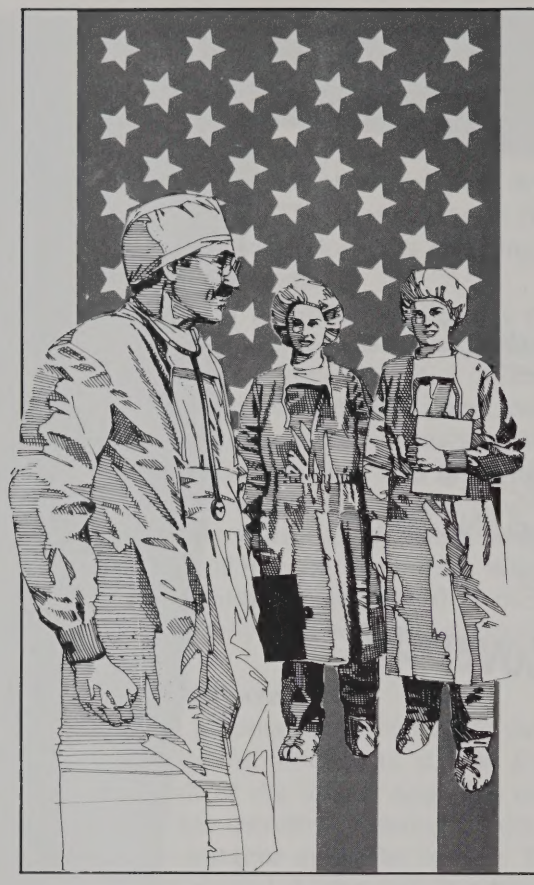

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